ADAP and Medicare Part D: Frequently Asked Questions
Updated 1/18/06

Starting January 1, 2006, Medicare will offer prescription drug coverage to all people with Medicare. This new drug program will be available under Medicare Part D (also referred to as "Medicare Rx") and will be administered through private drug plans.

Please note that the following information pertains solely to the California AIDS Drug Assistance Program (ADAP) as it interfaces with Medicare Part D. The material presented is in a "question and answer" format, and specifically addresses information requested by HIV-service providers. These questions are not intended to address all aspects of Medicare Part D. General information relating to Medicare Part D can be obtained at www.medicare.gov.

This list of questions and answers will be updated as needed, and service providers are invited to send additional ADAP related questions to jcross1@dhs.ca.gov for inclusion at a later date.

Medi-Cal Emergency Medicare Modernization Act (MMA) Drug Supply Program

Effective on the evening of January 12, 2006, Medi-Cal implemented a temporary program to provide emergency payment for prescription drugs to persons who are dually eligible for Medi-Cal and Medicare. This emergency program is available to all dually eligible persons including individuals who have a Medi-Cal share-of-cost and individuals who are enrolled in Medi-Cal managed care plans. This emergency coverage is only available in cases where the pharmacy has attempted and been unable to obtain reimbursement from the Medicare drug plan. Dually eligible beneficiaries who receive coverage under the Emergency MMA Drug Supply Program will still be required to pay the $1-$5 Medicare drug plan co-payment. *ADAP is able to assist with Medicare co-payments ($5 maximum) associated with ADAP formulary medications only.*

The Medi-Cal Emergency MMA Drug Supply Program is scheduled to expire at 11:59 p.m. on January 27, 2006.

Detailed information regarding the terms of this program can be located at www.medi-cal.ca.gov.

I. Enrollment Questions

1. Q: Are Medicare-eligible ADAP clients required to enroll in Medicare Part D?

Yes. ADAP is the payer of last resort. Federal and State requirements mandate that Medicare-eligible beneficiaries utilize Part D coverage before accessing ADAP coverage. Medicare-eligible ADAP clients will be required to enroll in either a Medicare

Prescription Drug Plan (PDP), a Medicare Advantage Prescription Drug Plan (MA-PD), or provide ADAP with documentation of creditable coverage (see creditable coverage question #I 11) ADAP will be able to help cover some of the out-of-pocket costs associated with Part D coverage.

2. Q: When will ADAP require clients to enroll in a Medicare drug plan?

Persons who are currently eligible for Medicare Part A or B are eligible for Part D prescription benefits effective January 1, 2006 and should enroll immediately. **ADAP requires clients to sign-up with either a PDP or an MA-PD immediately.** If the client has creditable coverage (e.g., private insurance with a prescription benefit Medicare considers to be comparable to Part D), they must provide a certificate of creditable coverage provided by their private insurance company to their ADAP enrollment counselor immediately.

Effective January 1, 2006, ADAP will allow temporary 30-day prescription supplies of medications to be dispensed to Medicare-eligible ADAP clients but only upon receipt of a required prior authorization. **ADAP coverage will be terminated for any client who does not enroll in a Medicare drug plan or demonstrate creditable coverage by March 31, 2006.**

3. Q: What is a Medicare drug plan?

Medicare drug plans will be offered by insurance companies and other private companies approved by Medicare. There are two types of Medicare drug plans, Medicare Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs). A PDP is a stand alone plan that only provides prescription drug coverage. MA-PDs are typically associated with managed care organizations (HMOs or PPOs). Individuals who assign their Part D coverage to an MA-PD will generally receive both their healthcare and prescription coverage from that organization.

You can find a comprehensive list of all plans available in your area in the Medicare & You 2006 handbook mailed to you by Medicare. Plan information is also available at www.medicare.gov.

4. Q: How do clients sign-up for Part D coverage?

How an individual signs-up for Part D will depend on the combination of healthcare benefits they receive.

Medicare-Only: If Medicare is the individual's only health coverage, they can enroll in a PDP or MA-PD anytime during Medicare's Part D open enrollment period December 15, 2005 - May 15, 2006. Enrollment can take place in one of the following ways:

On the web at www.medicare.gov

Contacting a PDP or MA-PD directly

Calling 1-800-MEDICARE

Medicare & Medi-Cal: If the individual is dually eligible for Medicare and Medi-Cal, he/she has been automatically assigned to a randomly selected Medicare prescription drug plan. In late October 2005, the client should have received a yellow letter indicating their auto-enrolled prescription drug plan. It is important that dually eligible clients understand which plan they have been assigned to in order to identify whether the plan will meet their prescription drug needs. If a client does not remember receiving a letter, he/she can obtain the assigned plan information by calling 1-800-MEDICARE. If the individual is not satisfied with the plan they have been auto-enrolled in, they have the right to change plans. When considering changing plans, it is important for the client to ask if they will be expected to pay any additional Part D out-of-pocket costs associated with premiums or co-payments. Also it is important for the client to understand that California's ADAP will not be able to assist in paying premium costs.

Medicare and Coverage through an Employer or Union: Because Part D coverage can impact employer health coverage in various ways, Medicare advises individuals to contact their employee benefits administrator to fully understand their prescription drug coverage options. If the employer or union-based prescription coverage is considered to be comparable to the standard Medicare prescription coverage, the client is deemed to have "creditable coverage" and therefore will not be required to apply for Part D coverage. The employer's plan sponsor should have provided individuals with proof of creditable coverage by November 15, 2005 (this information may have been included as part of the plan's explanation of benefits booklet). If the client is a Medicare beneficiary and an ADAP client who plans on remaining in an employer or union based plan, they must provide a copy of their creditable coverage certificate to their ADAP enroller as soon as possible.

5. Q: Are clients allowed to change Medicare drug plans?

Clients who are dually eligible for both Medi-Cal and Medicare are permitted to change plans at any time. For others who join a Medicare drug plan, changes can be made once a year during open enrollment (from November 15 through December 31). Enrollment is generally for the calendar year but exceptions can be made if the individual moves outside of the plan area or enters a nursing home.

6. Q: What should a client consider when selecting a PDP or MA-PD?

- Plan formulary: Each plan has a list of drugs that they will cover. Medicare requires that all plans cover anti-HIV medications. However, some plans may not cover other medications that a client needs, so it is important that they review the plan formulary to determine which plan best meets their needs.

- Pharmacy Networks: Each plan has specific pharmacies that will work with that plan's members. It is important that clients select a plan that is also in the ADAP pharmacy network.
- Monthly Premiums: Some plans charge monthly premiums. Persons with limited income may be eligible to receive extra help from Medicare to cover the average cost of the premium. **ADAP will not pay Part D premiums.** This should be taken into consideration when selecting a plan.

7. Q: How can enrollment counselors help someone decide between a PDP or an MA-PD?

Choosing between a PDP and an MA-PD is really a matter of personal preference. When assisting a client with this choice, it is important to help the individual understand the impact that their Part D selection will have on the way they receive all of their healthcare services. For example, it is important to help the client understand the difference between signing-up for stand-alone drug coverage under a PDP vs. signing-up to receive both their drug coverage and healthcare from an MA-PD.

8. Q: Is enrolling in Medicare Part D the same as selecting a drug plan?

Yes. When a person enrolls in a Medicare Prescription Drug Plan or Medicare Advantage Prescription Drug Plan, they have signed-up to receive Medicare Part D coverage.

9. Q: Where can I find a general list of PDP and MA-PD plans?

The following website lists PDPs and MA-PDs by state:

www.cms.hhs.gov/PrescriptionDrugCovGenIn/

10. Q: How often can plans increase premiums?

Annually.

11. Q: If the client is eligible for Medicare and does not enroll in a Medicare drug plan, will they be dropped from ADAP?

Yes. ADAP requires that clients sign-up with either a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) immediately. If the client has creditable coverage (e.g. private insurance with a prescription benefit Medicare considers to be comparable to Part D), they are required to provide a certificate of creditable coverage to their ADAP enrollment counselor immediately. **ADAP coverage will be terminated for clients who do not enroll in a Medicare drug plan or demonstrate creditable coverage by March 31, 2006.**

12. Q: What resources in addition to case managers and ADAP enrollment counselors can clients and others use to assist with drug plan selections?

The Medicare website, www.medicare.gov, offers a "Plan Locator" search tool that provides the individual with a list of optimal plans based on the individual's zip code and current medication needs. This service is also available by calling 1-800-MEDICARE.

Also, each county has an assigned local agency that provides free advocacy services to Medicare beneficiaries. Health Insurance Counseling and Advocacy Programs (HICAP) are available in every county in California. Although HICAP staff are not HIV benefits specialists, they are trained to assist with general Medicare issues. To locate the HICAP in your county call (800) 434-0222 or go to www.calmedicare.org.

13. Q: Who are "authorized reps" that can assist with Medicare drug plan selection for cognitively impaired clients?

If someone has the legal right to make health care decisions on a client's behalf (such as through a Power of Attorney), this person can enroll the client in the prescription drug plan that meets the client's needs.

II. Formulary Questions

1. Q: Where can clients find lists of Medicare drug plan covered medication or formulary information?

Specific formulary information is available on the Medicare website, www.medicare.gov, under "Drug Plan Finder".

2. Q: When comparing Medicare drug plans, none show Aptivus as covered. Most show it as non-formulary. Should it be on formularies without prior authorization?

Aptivus should be included on all Medicare drug plan formularies as it is classified as an anti-HIV medication. Aptivus was not initially included on many plans' formularies because these formularies were published before Aptivus was approved by the Food and Drug Administration. PDP formularies should be updated to reflect all anti-HIV medications on the market as of 1/1/06.

3. Q: How will clients access nutritional supplements? Will Medi-Cal continue to pay for Boost or does it fall under "wasting" which is included in Medicare Part D?

Nutritional supplements such as "Boost" are considered to be "over-the-counter" products. Dual eligible clients who medically require these products will continue to receive these products under Medi-Cal. Over-the-counter products are not reimbursable under Medicare Part D plans.

4. Q: Will hormone therapy be covered for transgender clients?

Medicare drug plans are permitted to cover hormone therapy. Transgender persons should check with the individual plans to evaluate which medications are covered and the plan's dispensing criteria.

5. Q: How will co-infected persons with Hepatitis C get their drugs?

Medicare eligible individuals should attempt to access these medications through their Medicare PDP or MA-PD. Co-infected individuals should use the Medicare "Formulary Finder" when selecting a plan to identify a Medicare drug plan that will provide access to all needed medications.

6. Q: How often will a Medicare drug plan change its formulary?

No changes are allowed between October 2005 and March 2006. Starting in March 2006, plans will be allowed to change their formulary on a monthly basis from the 1st to the 7th of every month. Medicare will review all changes for continued compliance with the guidelines. Formulary information contained in the Medicare "Drug Plan Finder" will be updated on a monthly basis to reflect any approved changes after March 2006.

7. Q: Will the Medicare drug plan notify the client of changes in the formulary?

Yes. Plans are required to notify their affected beneficiaries, providers, pharmacy networks and Medicare in writing at least 60 days in advance of all changes. Such changes include: drugs removed from the formulary, drugs moved to a higher cost share tier, or the placement of any increased utilization management tool. The 60-day rule is not in effect if a drug is removed from the market.

8. Q: Will the Medicare drug plan provide a 30-day supply upon changes to the formulary?

Medicare drug plans are required to give a 60-day notice to affected enrollees if they remove a Medicare-covered prescription from their formularies. If the notice requirement is not met, plans must provide affected enrollees with a 60-day supply of the medication in dispute and provide the enrollee with a notice of the change when the enrollee requests a refill.

9. Q: Are all Medicare drug plans required to cover all medications?

No. Each Medicare drug plan will have an individually developed formulary. Medicare established certain rules that each drug plan must follow when developing a formulary. Specifically, Medicare indicated it will not award plan contracts to Medicare drug plans that do not cover all medications included in the following classes, as long as the drugs are FDA approved and on the market as of January 1, 2006:

- **Antiretrovirals**
- **Antidepressants**
- **Anticonvulsants**
- **Antipsychotics**
- **Antineoplastics**
- **Immunosuppressants**

For medications not included in the above list, Medicare drug plans are permitted to cover FDA-approved medications, used and sold in the United States, and used for a medically accepted indication. Although plans are permitted to cover all of these medications, Medicare only requires each plan to cover two drugs per drug class.

Medicare also designated a list of certain drugs that are considered to be "excluded drugs", meaning that they are not covered drugs under Medicare Part D. These drugs include:

- Drugs for anorexia, weight loss, or weight gain (**not including anti-wasting medications**)
- Fertility, medications for cosmetic purposes or hair growth
- Symptomatic relief of colds and coughs
- Prescription vitamin and mineral products
- Over-the-counter drugs
- Barbiturates
- Benzodiazepines

10. Q: What should clients do if they need a medication that is on the excluded drug list?

Dual eligible clients will still be permitted to receive medications that are on the above list under their Medi-Cal coverage. The ADAP formulary covers two medications that are excluded under Part D, specifically two Benzodiazepines, Ativan and Xanax. Medicare only clients will be permitted to access these medications through ADAP.

11. Q: Will ADAP cover medications that are not on the Medicare drug plan formulary?

Medicare eligible clients will be permitted to access drugs that are on the ADAP formulary if they have completed the Medicare drug plan's exception request process and are able to provide ADAP with an exception request denial. In order to avoid the exception request process, individuals should select the Medicare drug plan that best meets their formulary needs. Also, it is imperative that clients understand that ADAP will only be able to cover medications that are on the ADAP formulary.

12. Q: What is an exception request? How long does it take?

Medicare drug plans are required to offer an exception request process to all plan members. This process is intended to allow the client the ability to access a medically necessary drug. There are two types of exception requests:

- **Formulary exceptions** allows the client to request a prescription drug that is not on the plan formulary;
- **Tiering exceptions** allows the client to obtain a drug at a more favorable cost-sharing level.

The Medicare drug plan must notify the client and the prescribing physician involved of its decision within 24 hours for expedited requests, or within 72 hours for standard requests. An expedited request is any request where the physician indicates that the standard timeframe may seriously jeopardize the client's health or their ability to regain maximum function.

If the client is denied at the exception request level, they are permitted to continue to pursue the request through the Medicare drug plan appeals process.

13. Q: How long will an exception authorization last?

Exception requests are good for the remainder of the plan year. Once a plan approves an exception request, it cannot require that enrollees go through additional exception requests for refills.

14. Q: Will ADAP cover medications during an exception request (24-72 hours)?

No. ADAP will not cover medications during the exceptions request process. ADAP does not anticipate that this policy will jeopardize anti-HIV medication adherence, because all anti-HIV medications are required to be included on all Medicare drug plan formularies, thus, it is not expected that clients will have to use the exception request process for anti-HIV medications.

III. Part D Related Client Costs:

1. Q: Some Medicare drug plans will require clients to pay a premium, deductible, co-insurance and co-payments. Will ADAP assist with these costs?

ADAP will pay Medicare drug plan prescription deductibles, co-insurance, and co-payments ***for medications on the ADAP formulary. However, ADAP will not pay monthly premiums.***

Persons who utilize ADAP to pay their Medicare drug plan costs will be required to apply for, and utilize Medicare's "Extra Help" subsidy assistance.

2. Q: Will CARE-HIPP pay Medicare Part D premiums?

In 2006 CARE-HIPP will not cover the cost of Medicare drug plan premiums. The Office of AIDS will continue to explore the possibility of this option for the future.

3. Q: Where can I find the costs associated with each plan?

The Medicare website, www.medicare.gov, offers a "Plan Compare" search tool. This tool provides a cost comparison list of plans in your area.

4. **Q: Part D only pays for part of the prescription drug costs before the "donut-hole" kicks in. What happens then? Will the client have to pay for the rest of the drugs?**

Because the federal Centers for Medicare and Medicaid Services has specifically excluded ADAP payments as counting toward beneficiaries' Part D "True out-of pocket", or TrOOP drug costs, any payment made by ADAP on a beneficiary's behalf will not be credited as TrOOP. Because ADAP payments will not count towards TrOOP, it is anticipated that some beneficiaries will need to utilize full ADAP coverage once they encounter the gap in Part D coverage where the beneficiary assumes 100 percent of their drug costs (also referred to as "the donut hole"). In other words, once the client hits their "donut hole," ADAP will take over covering the cost of drugs on the ADAP drug formulary. The client may have out-of-pocket costs during the "donut hole" if they are taking drugs that are medications that are not on the ADAP formulary. If the client pays for these medications directly, the cost of the drugs will count as TrOOP and may help the client move back into Medicare coverage under the catastrophic threshold.

5. Q: How will clients keep track of TrOOP costs?

Medicare has contracted with a company who will be responsible for tracking each beneficiary's drug utilization and costs. ADAP has registered with this company to coordinate TrOOP calculation efforts. It is imperative that clients disclose all sources of drug coverage (including ADAP) to Medicare so that accurate payment can be made on the client's behalf. Clients are also encouraged to maintain all prescription drug receipts in case TrOOP calculation corrections are necessary.

6. Q: Will monthly premiums be deducted from the client's Social Security benefit?

Yes. Although Medicare will allow other premium payment options (direct billing), any client who wishes to utilize ADAP to meet their Medicare drug plan prescription costs, will be required to pay their premiums via withdrawal from their monthly Social Security check. This will ensure continuation of Part D coverage with little risk for interruption.

IV. Medicare & Medi-Cal, ("Dual Eligible") Beneficiary Questions:

1. Q: Can Eligible Metropolitan Areas (EMAs) with Title I or II funds pay Medicare drug plan costs?

Federal policy allows Title I and Title II funds to be used to cover Medicare drug plan costs, but these costs will not be counted as TrOOP. Title I and Title II payments for a beneficiary's drug plan costs must be paid directly to the Medicare drug plan **and not to the client**.

2. Q: Will ADAP cover medication costs for dual eligible clients?

Dual eligible clients will receive their primary prescription drug coverage from their Medicare drug plan. In 2006, dual eligible clients will be eligible for Medicare's Full Low Income Subsidy. This subsidy will limit their Medicare drug plan costs to co-payments only (for cost-average plans). ADAP is able to assist with Medicare drug plan $1-$5 co-payments associated with ADAP formulary medications only. In order to receive ADAP assistance, dual eligible clients must also be enrolled in ADAP.

3. Q: Will ADAP cover a dual eligible person's medications if the medications are on the ADAP formulary but not on the Medicare drug plan's formulary?

Any Medicare eligible client will be permitted to access drugs that are on the ADAP formulary if they have completed the Medicare drug plan exception request process and received a denial from the drug plan. All clients are required to provide the exception request denial documentation to ADAP before ADAP will cover the drug.

4. Q: Will ADAP continue to cover a dual eligible person's Medi-Cal Share-of-Cost after January 1, 2006?

No. As of January 1, 2006, persons who are "dually eligible" for Medicare and Medi-Cal will no longer receive drug coverage under Medi-Cal (with the exception of drugs outlined in question #IV. 14). Clients who are dually eligible will access drug coverage under Medicare Part D. Because these clients will no longer have drug coverage associated with their Medi-Cal, there will be no Medi-Cal prescription drug cost to allow ADAP payment toward the Medi-Cal Share-of-Cost. Thus, dual eligible clients will be responsible for paying their Share-of-Cost for Medi-Cal covered services.

5. Q: What are some strategies for assisting dual eligible clients with reducing their Medi-Cal Share-of-Cost?

Clients may use medical expenses to reduce their monthly Medi-Cal Share-of-Cost obligation. These include:

- Unpaid bills for medical services received from non-Medi-Cal providers
- Past due bills for medical services the client received prior to becoming eligible for Medi-Cal.

Clients attempting to adjust their Share-of-Cost should take receipts demonstrating any of the above situations to their Medi-Cal Eligibility Worker.

6. Q: Will clients who had a Medi-Cal Share-of-Cost in 2005 be automatically eligible for the "Full Extra Help Subsidy"?

Yes. In mid-December 2005, Medicare clarified that any person who was Medi-Cal eligible by December 31, 2005 would be eligible for the full subsidy. This was a change in their original policy that a person would have had to meet their Share-of-Cost in one month in 2005 to receive the subsidy.

7. Q: How does the "Low Income Subsidy" work with or impact a client's Medi-Cal Share-of-Cost?

It is important to recognize that the term "Low Income Subsidy" is a Medicare term that applies to the cost sharing reduction that a dually eligible person will automatically receive for their Medicare drug plan costs. A "Share-of-Cost" is a Medi-Cal term that refers to a specific dollar amount, based on a person's income that must be spent on medical costs before a person is entitled to Medi-Cal benefits.

Because a dual eligible person will now receive drug coverage under Medicare and the Low Income Subsidy, it is expected that many individuals will have significantly reduced monthly medical costs to spend down and will therefore not meet their Medi-Cal Share-of-Cost as frequently.

8. Q: Can EMAs who receive Ryan White Care Act Title I or II funds pay a client's Medi-Cal Share-of-Cost?

Federal policy prohibits the use of Ryan White funds to pay an individual's Medi-Cal Share-of-Cost.

9. Q: What if a client disenrolls from Medi-Cal?

Persons who are utilizing ADAP to cover their Medicare drug plan costs will be required to maintain their Medi-Cal coverage. This will ensure that ADAP and other Ryan White

care providers maintain their payer-of-last resort status. It will also ensure that clients are receiving the maximum healthcare benefits available to them, such as payment of Medicare Part A and B deductibles and co-payments, and payment of their monthly Medicare Part B premiums.

10. Q: Which Medicare drug plans will dually eligible persons be auto-assigned to?

Medicare has designated certain plans as eligible to receive auto-enrolled beneficiaries. These plans are considered to be "cost average" plans available in the region. Dual eligible persons do have the right to enroll in higher cost plans, but they will become responsible for any non-subsidized costs such as premium costs.

11. Q: Are dual eligible clients permitted to change Medicare drug plans?

Yes. Dually eligible individuals are eligible for what is called a "continuous Special Enrollment Period." This means that they are permitted to change Medicare drug plans monthly.

12. Q: What is the process for changing Medicare drug plans?

Dual eligible persons have several options for changing drug plans. The client may disenroll by:

- contacting Medicare directly;
- notifying their current drug plan; or
- simply signing-up with a new plan.

If the client enrolls in a new drug plan while still enrolled in another plan, he/she will be automatically disenrolled from the old plan.

13. Q: How will dual eligible clients know which Medicare drug plan they have been auto-enrolled in?

Dual eligible clients were mailed a letter in late October 2005, notifying them of their automatic Medicare drug plan assignment. Clients may also contact Medicare at www.medicare.gov or 1-800-MEDICARE to find out their plan information. A Medicare Part D participating pharmacy should also be able to identify the client's plan assignment.

14. Q: Can a dual eligible client seek Medi-Cal coverage for drugs that are not on their Medicare drug plan's formulary.

Medi-Cal will only continue to cover certain categories of medications that are considered "excluded drugs" under Medicare Part D. These categories include:

- Prescription vitamins and minerals
- Non-prescription "over-the-counter" medications
- Medications used for cold and cough symptoms

- Benzodiazepines
- Barbiturates
- Drugs used for anorexia, weight loss, or weight gain

15. Q: If a dual eligible client with a Medi-Cal Share-of-Cost receives a Medi-Cal covered Part D "excluded drug, can ADAP pay the drug cost towards the person's Medi-Cal Share-of-Cost?

Yes. At this time, there are only two Medicare Part D excluded medications on the ADAP formulary, Xanax and Ativan. ADAP will pay towards a Medi-Cal Share-of-Cost for these medications only. Because these drugs are relatively inexpensive, clients should not anticipate that this coverage will meet their entire monthly Medi-Cal Share-of-Cost.